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SENATE BILL 3471
By Herron

HOUSE BILL 3276
By Fitzhugh

AN ACT to amend Tennessee Code Annotated, Title 4; Title 56; Title 67; Title 68 and Title 71, relative to the "Healthy Tennessee Act of 2006".

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, is amended by adding the following as a new chapter:

56-58-101. The title of this act is the "Healthy Tennessee Act of 2006", and it may be cited as the “Healthy Tennessee Act”.

56-58-102. As used in this act, unless the context otherwise requires:

(1) "Commissioner" means the commissioner of commerce and insurance; and

(2) "Program" means the Healthy Tennessee program established by this chapter.

56-58-103.

(a) A Healthy Tennessee program is hereby established for the purpose of making standardized health insurance contracts available to qualifying small employers and qualifying individuals as defined in this section. Such program is designed to encourage small employers to offer health insurance coverage to their employees and to also make coverage available to uninsured employees whose employers do not provide group health insurance.

(b) Participation in the program established by this section and section 56-58-104 is limited to corporations or insurers organized or licensed under this title and health maintenance organizations issued a certificate of authority under or licensed under this title. Participation by all health maintenance organizations

is mandatory. On and after January 1, 2007, all health maintenance organizations shall offer qualifying group health insurance contracts and qualifying individual health insurance contracts as defined in this section. For the purposes of this section and 56-58-104 of this chapter, corporations or insurers operating under this title which voluntarily participate in compliance with the requirements of this program shall be eligible for reimbursement from the stop loss funds created pursuant to 56-58-104 under the same terms and conditions as health maintenance organizations.

(c) The following definitions shall be applicable to the insurance contracts offered under the program established by this section:

(1) A qualifying small employer is an employer that is either:

(A) An individual proprietor who is the only employee of the business:

(i) without health insurance which provides benefits on an expense reimbursed or prepaid basis in effect during the twelve (12) month period prior to application for a qualifying group health insurance contract under the program established by this section; and

(ii) resides in a household having a net household income at or below two hundred fifty percent (250%) of the non-farm federal poverty level (as defined and updated by the federal department of health and human services) or the gross equivalent of such net income; or

(iii) except that the requirements set forth in item (i) of this subdivision shall not be applicable where an

individual proprietor had health insurance coverage during the previous twelve (12) months and such coverage terminated due to one of the reasons set forth in items (i) through (viii) of subdivision (c)(3)(C) of this section; or

(B) An employer with:

(i) not more than fifty (50) eligible employees;

(ii) no group health insurance which provides benefits on an expense reimbursed or prepaid basis covering employees in effect during the twelve (12) month period prior to application for a qualifying group health insurance contract under the program established by this section; and

(iii) at least thirty percent (30%) of its eligible employees receiving annual wages from the employer at a level equal to or less than thirty-three thousand dollars ($33,000). The thirty-three thousand dollar ($33,000) figure shall be adjusted periodically pursuant to subdivision (E) of this paragraph.

(C) The twelve (12) month period set forth in item (i) of subdivision (A) of this paragraph and in item (ii) of subdivision (B) of this paragraph may be adjusted by the commissioner from twelve (12) months to eighteen (18) months if the commissioner determines that the twelve (12) month period is insufficient to prevent inappropriate substitution of other health insurance contracts for qualifying group health insurance contracts.

(D) An individual proprietor or employer shall cease to be a qualifying small employer if any health insurance which provides benefits on an expense reimbursed or prepaid basis covering the individual proprietor or an employer's employees, other than qualifying group health insurance purchased pursuant to this section, is purchased or otherwise takes effect subsequent to purchase of qualifying group health insurance under the program established by this section.

(E) The wage levels utilized in subdivision (B) of this paragraph shall be adjusted annually, beginning in 2008. The adjustment shall take effect on July 1 of each year. For July 1, 2008, the adjustment shall be a percentage of the annual wage figure specified in subdivision (B) of this paragraph. For subsequent years, the adjustment shall be a percentage of the annual wage figure which took effect on July 1 of the prior year. The percentage adjustment shall be the same percentage by which the current year's non-farm federal poverty level, as defined and updated by the federal department of health and human services, for a family unit of four (4) persons for the forty-eight (48) contiguous states and Washington, D.C., changed from the same level established for the prior year.

(2) A qualifying group health insurance contract is a group contract purchased from a health maintenance organization, corporation or insurer by a qualifying small employer which provides the benefits set

forth in subsection (d) of this section. The contract must insure not less than fifty percent (50%) of the employees eligible for coverage.

(3)

(A) A qualifying individual is an employed person:

(i) who does not have and has not had health insurance with benefits on an expense reimbursed or prepaid basis during the twelve (12) month period prior to the individual's application for health insurance under the program established by this section;

(ii) whose employer does not provide group health insurance and has not provided group health insurance with benefits on an expense reimbursed or prepaid basis covering employees in effect during the twelve (12) month period prior to the individual's application for health insurance under the program established by this section;

(iii) resides in a household having a net household income at or below two hundred fifty percent (250%) of the non-farm federal poverty level (as defined and updated by the federal department of health and human services) or the gross equivalent of such net income;

(iv) is ineligible for Medicare.

(B) The requirements set forth in items (i) and (ii) of subdivision (A) of this paragraph shall not be applicable where an individual had health insurance coverage during the previous twelve (12) months and such coverage terminated due to:

(i) loss of employment due to factors other than voluntary separation;

(ii) death of a family member which results in termination of coverage under a health insurance contract under which the individual is covered;

(iii) change to a new employer that does not provide group health insurance with benefits on an expense reimbursed or prepaid basis;

(iv) change of residence so that no employer-based health insurance with benefits on an expense reimbursed or prepaid basis is available;

(v) discontinuation of a group health insurance contract with benefits on an expense reimbursed or prepaid basis covering the qualifying individual as an employee or dependent;

(vi) expiration of the coverage periods established by the continuation provisions of the Employee Retirement Income Security Act, 29 U.S.C. section 1161 et seq. and the Public Health Service Act, 42 U.S.C. section 300bb-1 et seq. established by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended;

(vii) legal separation, divorce or annulment which results in termination of coverage under a health insurance contract under which the individual is covered; or

(viii) loss of eligibility under a group health plan.

(C) The twelve (12) month period set forth in items (i) and (ii) of subdivision (A) of this paragraph may be adjusted by the commissioner from twelve (12) months to eighteen (18) months if he determines that the twelve month period is insufficient to prevent inappropriate substitution of other health insurance contracts for qualifying individual health insurance contracts.

(4) A qualifying individual health insurance contract is an individual contract issued directly to a qualifying individual and which provides the benefits set forth in subsection (d) of this section. At the option of the qualifying individual, such contract may include coverage for dependents of the qualifying individual.

(d) The contracts issued pursuant to this section by health maintenance organizations, corporations or insurers and approved by the commissioner shall only provide in-plan benefits, except for emergency care or where services are not available through a plan provider. Covered services shall include only the following:

(1) inpatient hospital services consisting of daily room and board, general nursing care, special diets and miscellaneous hospital services and supplies;

(2) outpatient hospital services consisting of diagnostic and treatment services;

(3) physician services consisting of diagnostic and treatment services, consultant and referral services, surgical services (including breast reconstruction surgery after a mastectomy), anesthesia services, second surgical opinion, and a second opinion for cancer treatment;

(4) outpatient surgical facility charges related to a covered surgical procedure;

(5) preadmission testing;

(6) maternity care;

(7) adult preventive health services consisting of mammography screening; cervical cytology screening; periodic physical examinations no more than once every three (3) years; and adult immunizations;

(8) preventive and primary health care services for dependent children including routine well-child visits and necessary immunizations;

(9) equipment, supplies and self-management education for the treatment of diabetes;

(10) diagnostic x-ray and laboratory services;

(11) emergency services;

(12) therapeutic services consisting of radiologic services, chemotherapy and hemodialysis;

(13) blood and blood products furnished in connection with surgery or inpatient hospital services; and

(14) prescription drugs obtained at a participating pharmacy. In addition to providing coverage at a participating pharmacy, health maintenance organizations may utilize a mail order prescription drug program. Health maintenance organizations may provide prescription drugs pursuant to a drug formulary; however, health maintenance organizations must implement an appeals process so that the use of non-formulary prescription drugs may be requested by a physician.

(e) The benefits provided in the contracts described in subsection (d) of this section shall be subject to the following deductibles and copayments:

(1) in-patient hospital services shall have a five hundred dollar ($500) copayment for each continuous hospital confinement;

(2) surgical services shall be subject to a copayment of the lesser of twenty percent (20%) of the cost of such services or two hundred dollars ($200) per occurrence;

(3) outpatient surgical facility charges shall be subject to a facility copayment charge of seventy-five dollars ($75) per occurrence;

(4) emergency services shall have a fifty dollar ($50) copayment which must be waived if hospital admission results from the emergency room visit;

(5) prescription drugs shall have a one hundred dollar ($100) calendar year deductible per individual. After the deductible is satisfied, each thirty-four (34) day supply of a prescription drug will be subject to a copayment. The copayment will be ten dollars ($10) if the drug is generic. The copayment for a brand name drug will be twenty dollars ($20) plus the difference in cost between the brand name drug and the equivalent generic drug. If a mail order drug program is utilized, a twenty dollar ($20) copayment shall be imposed on a ninety (90) day supply of generic prescription drugs. A forty dollar ($40) copayment plus the difference in cost between the brand name drug and the equivalent generic drug shall be imposed on a ninety (90) day supply of brand name prescription drugs. In no event shall the copayment exceed the cost of the prescribed drug;

(6) the maximum coverage for prescription drugs shall be three thousand dollars ($3,000) per individual in a calendar year; and

(7) all other services shall have a twenty dollar ($20) copayment, with the exception of prenatal care, which shall have a ten dollar ($10) copayment.

(f) Except as included in the list of covered services in subsection (d) of this section, the mandated and make-available benefits set forth in chapter 7 of this title shall not be applicable to the contracts issued pursuant to this section. Mandated benefits included in such contracts shall be subject to the deductibles and copayments set forth in subsection (e) of this section.

(g) The commissioner shall be authorized to modify, by regulation, the copayment and deductible amounts described in this section if the commissioner determines such amendments are necessary to facilitate implementation of this section. On or after January 1, 2008, the commissioner shall be authorized to establish, by regulation, one or more additional standardized health insurance benefit packages if the commissioner determines additional benefit packages with different levels of benefits are necessary to meet the needs of the public.

(h) A health maintenance organization, corporation or insurer must offer the benefit package without change or additional benefits. Qualifying small employers shall be issued the benefit package in a qualifying group health insurance contract. Qualifying individuals shall be issued the benefit package in a qualifying individual health insurance contract.

(i) A health maintenance organization, corporation or insurer shall obtain from the employer or individual written certification at the time of initial application and annually thereafter ninety (90) days prior to the contract renewal date that

such employer or individual meets the requirements of a qualifying small employer or a qualifying individual pursuant to this section. A health maintenance organization, corporation or insurer may require the submission of appropriate documentation in support of the certification.

(j) Applications for qualifying group health insurance contracts and qualifying individual health insurance contracts must be accepted from any qualifying individual and any qualifying small employer at all times throughout the year. The commissioner, by regulation, may require health maintenance organizations, corporations or insurers to give preference to qualifying small employers whose eligible employees have the lowest average salaries.

(k) All coverage under a qualifying group health insurance contract or a qualifying individual health insurance contract shall be subject to the pre-existing condition limitation provided in 56-7-2803, including the crediting requirements thereunder. The underwriting of such contracts may not involve more than the imposition of a pre-existing condition limitation.

(l) A qualifying small employer shall elect whether to make coverage under the qualifying group health insurance contract available to dependents of employees. Any employee or dependent who is enrolled in Medicare is ineligible for coverage, unless required by federal law. Dependents of an employee who is enrolled in Medicare will be eligible for dependent coverage provided the dependent is not also enrolled in Medicare.

(m) A qualifying small employer must pay at least fifty percent (50%) of the premium for employees covered under a qualifying group health insurance contract and must offer coverage to all employees receiving annual wages at a level of thirty-three thousand dollars ($33,000) or less, and at least one such

employee shall accept such coverage. The thirty-three thousand dollar ($33,000) wage level shall be adjusted periodically in accordance with subdivision (E) of subsection (c)(1) of this section. The employer premium contribution must be the same percentage for all covered employees.

(n) Premium rate calculations for qualifying group health insurance contracts and qualifying individual health insurance contracts shall be subject to the following:

(1) coverage must be community rated and include rate tiers for individuals, two (2) adult families and at least one other family tier. The rate differences must be based upon the cost differences for the different family units and the rate tiers must be uniformly applied. The rate tier structure used by a health maintenance organization, corporation or insurer for the contracts issued to qualifying small employers and to qualifying individuals must be the same;

(2) if geographic rating areas are utilized, such geographic areas must be reasonable and in a given case may include a single county. The geographic areas utilized must be the same for the contracts issued to qualifying small employers and to qualifying individuals. The commissioner shall not require the inclusion of any specific geographic region within the proposed community rated region selected by the health maintenance organization, corporation or insurer so long as the health maintenance organization, corporation or insurer's proposed regions do not contain configurations designed to avoid or segregate particular areas within a county covered by the health maintenance organization, corporation or insurer's community rates.

(3) claims experience under contracts issued to qualifying small employers and to qualifying individuals must be pooled for rate setting purposes. The premium rates for qualifying group health insurance contracts and qualifying individual health insurance contracts must be the same.

(o) A health maintenance organization, corporation or insurer shall submit reports to the commissioner in such form and at times as may be reasonably required in order to evaluate the operations and results of the standardized health insurance program established by this section.

56-58-104.

(a) The commissioner shall establish a fund from which health maintenance organizations, corporations or insurers may receive reimbursement, to the extent of funds available, for claims paid by such health maintenance organizations, corporations or insurers for members covered under qualifying group health insurance contracts issued pursuant to § 56-58-103. This fund shall be known as the "small employer stop loss fund". The commissioner shall establish a separate and distinct fund from which health maintenance organizations, corporations or insurers may receive reimbursement, to the extent of funds available, for claims paid by such health maintenance organizations, corporations or insurers for members covered under qualifying individual health insurance contracts issued pursuant to § 56-58-103. This fund shall be known as the "qualifying individual stop loss fund".

(b) Commencing on January 1, 2007, health maintenance organizations, corporations or insurers shall be eligible to receive reimbursement for ninety percent (90%) of claims paid between thirty thousand dollars ($30,000) and one

hundred thousand dollars ($100,000) in a calendar year for any member covered under a standardized contract issued pursuant to § 56-58-103. Claims paid for members covered under qualifying group health insurance contracts shall be reimbursable from the small employer stop loss fund. Claims paid for members covered under qualifying individual health insurance contracts shall be reimbursable from the qualifying individual stop loss fund. For the purposes of this section, claims shall include health care claims paid by a health maintenance organization on behalf of a covered member pursuant to such standardized contracts.

(c) The commissioner shall promulgate regulations that set forth procedures for the operation of the small employer stop loss fund and the qualifying individual stop loss fund and distribution of monies therefrom.

(d) The small employer stop loss fund shall operate separately from the qualifying individual stop loss fund. Except as specified in subsection (b) of this section with respect to calendar year 2007, the level of stop loss coverage for the qualifying group health insurance contracts and the qualifying individual health insurance contracts need not be the same. The two stop loss funds need not be structured or operated in the same manner, except as specified in this section. The monies available for distribution from the stop loss funds may be reallocated between the small employer stop loss fund and the qualifying individual stop loss fund if the commissioner determines that such reallocation is warranted due to enrollment trends.

(e) Claims shall be reported and funds shall be distributed from the small employer stop loss fund and from the qualifying individual stop loss fund on a calendar year basis. Claims shall be eligible for reimbursement only for the

calendar year in which the claims are paid. Once claims paid on behalf of a covered member reach or exceed one hundred thousand dollars ($100,000) in a given calendar year, no further claims paid on behalf of such member in that calendar year shall be eligible for reimbursement.

(f) Each health maintenance organization, corporation or insurer shall submit a request for reimbursement from each of the stop loss funds on forms prescribed by the commissioner. Each of the requests for reimbursement shall be submitted no later than April 1 following the end of the calendar year for which the reimbursement requests are being made. The commissioner may require health maintenance organizations, corporations or insurers to submit such claims data in connection with the reimbursement requests as he deems necessary to enable him to distribute monies and oversee the operation of the small employer and qualifying individual stop loss funds. The commissioner may require that such data be submitted on a per member, aggregate and/or categorical basis. Data shall be reported separately for qualifying group health insurance contracts and qualifying individual health insurance contracts issued pursuant to § 56-58-103.

(g) For each stop loss fund, the commissioner shall calculate the total claims reimbursement amount for all health maintenance organizations, corporations or insurers for the calendar year for which claims are being reported.

(1) In the event that the total amount requested for reimbursement for a calendar year exceeds funds available for distribution for claims paid during that same calendar year, the commissioner shall provide for the pro-rata distribution of the available funds. Each health maintenance

organization, corporation or insurer shall be eligible to receive only such proportionate amount of the available funds as the individual health maintenance organization's, corporation's or insurer's total eligible claims paid bears to the total eligible claims paid by all health maintenance organizations, corporations or insurers.

(2) In the event that funds available for distribution for claims paid by all health maintenance organizations, corporations or insurers during a calendar year exceeds the total amount requested for reimbursement by all health maintenance organizations, corporations or insurers during that same calendar year, any excess funds shall be carried forward and made available for distribution in the next calendar year. Such excess funds shall be in addition to the monies appropriated for the stop loss fund in the next calendar year.

(h) Upon the request of the commissioner, each health maintenance organization shall be required to furnish such data as the commissioner deems necessary to oversee the operation of the small employer and qualifying individual stop loss funds. Such data shall be furnished in a form prescribed by the commissioner. Each health maintenance organization, corporation or insurer shall provide the commissioner with monthly reports of the total enrollment under the qualifying group health insurance contracts and the qualifying individual health insurance contracts issued pursuant to section four thousand three hundred twenty-six of this article. The reports shall be in a form prescribed by the commissioner. Each health maintenance organization, corporation or insurer shall provide the commissioner with monthly reports of the total enrollment under the qualifying group health insurance contracts and the qualifying individual

health insurance contracts issued pursuant to § 56-58-103. The reports shall be in a form prescribed by the commissioner.

(i) The commissioner shall separately estimate the per member annual cost of total claims reimbursement from each stop loss fund for qualifying individual health insurance contracts and for qualifying group health insurance contracts based upon available data and appropriate actuarial assumptions. Upon request, each health maintenance organization, corporation or insurer shall furnish to the commissioner claims experience data for use in such estimations.

(j) The commissioner shall determine total eligible enrollment under qualifying group health insurance contracts and qualifying individual health insurance contracts. For qualifying group health insurance contracts, the total eligible enrollment shall be determined by dividing the total funds available for distribution from the small employer stop loss fund by the estimated per member annual cost of total claims reimbursement from the small employer stop loss fund. For qualifying individual health insurance contracts, the total eligible enrollment shall be determined by dividing the total funds available for distribution from the qualifying individual stop loss fund by the estimated per member annual cost of total claims reimbursement from the qualifying individual stop loss fund.

(k) The commissioner shall suspend the enrollment of new employers under qualifying group health insurance contracts if the commissioner determines that the total enrollment reported by all health maintenance organizations, corporations or insurers under such contracts exceeds the total eligible enrollment, thereby resulting in anticipated annual expenditures from the small employer stop loss fund in excess of the total funds available for distribution from

such stop loss fund. The commissioner shall suspend the enrollment of new individuals under qualifying individual health insurance contracts if the commissioner determines that the total enrollment reported by all health maintenance organizations, corporations or insurers under such contracts exceeds the total eligible enrollment, thereby resulting in anticipated annual expenditures from the qualifying individual stop loss fund in excess of the total funds available for distribution from such stop loss fund.

(l) The commissioner shall provide the health maintenance organizations, corporations or insurers with notification of any enrollment suspensions as soon as practicable after receipt of all enrollment data. The commissioner's determination and notification shall be made separately for the qualifying group health insurance contracts and for the qualifying individual health insurance contracts.

(m) If at any point during a suspension of enrollment of new qualifying small employers and/or qualifying individuals, the commissioner determines that funds are sufficient to provide for the addition of new enrollments, the commissioner shall be authorized to reactivate new enrollments and to notify all health maintenance organizations, corporations or insurers that enrollment of new employers and/or individuals may again commence. The commissioner's determination and notification shall be made separately for the qualifying group health insurance contracts and for the qualifying individual health insurance contracts.

(n) The suspension of issuance of qualifying group health insurance contracts to new qualifying small employers shall not preclude the addition of

new employees of an employer already covered under such a contract or new dependents of employees already covered under such contracts.

(o) The suspension of issuance of qualifying individual health insurance contracts to new qualifying individuals shall not preclude the addition of new dependents to an existing qualifying individual health insurance contract.

(p) The premiums for qualifying group health insurance contracts must factor in the availability of reimbursement from the small employer stop loss fund. The premiums for qualifying individual health insurance contracts must factor in the availability of reimbursement from the qualifying individual stop loss funds.

(q) The commissioner may obtain the services of an organization to administer the stop loss funds established by this section. If the commissioner deems it appropriate, he or she may utilize a separate organization for administration of the small employer stop loss fund and the qualifying individual stop loss fund. The commissioner shall establish guidelines for the submission of proposals by organizations for the purposes of administering the funds. The commissioner shall make a determination whether to approve, disapprove or recommend modification to the proposal of an applicant to administer the funds. An organization approved to administer the funds shall submit reports to the commissioner in such form and at times as may be required by the commissioner in order to facilitate evaluation and ensure orderly operation of the funds, including, but not limited to, an annual report of the affairs and operations of the fund, such report to be delivered to the commissioner and to the chairs of the senate finance committee and the house finance, ways and means committee. An organization approved to administer the funds shall maintain records in a form prescribed by the commissioner and which shall be available for inspection by or

at the request of the commissioner. The commissioner shall determine the amount of compensation to be allocated to an approved organization as payment for fund administration. Compensation shall be payable from the stop loss coverage funds. An organization approved to administer the funds may be removed by the commissioner and must cooperate in the orderly transition of services to another approved organization or to the commissioner.

(r) If the commissioner deems it appropriate for the proper administration of the small employer stop loss fund and/or the qualifying individual stop loss fund, the administrator of the fund, on behalf of and with the prior approval of the commissioner, shall be authorized to purchase stop loss insurance and/or reinsurance from an insurance company licensed to write such type of insurance in this state. Such stop loss insurance and/or reinsurance may be purchased to the extent of funds available therefor within such funds which are available for purposes of the stop loss funds established by this section.

(s) The commissioner may access funding from the small employer stop loss fund and/or the qualifying individual stop loss fund for the purposes of developing and implementing public education, outreach and facilitated enrollment strategies targeted to small employers and working adults without health insurance. The commissioner may contract with marketing organizations to perform or provide assistance with such education, outreach, and enrollment strategies. The commissioner shall determine the amount of funding available for the purposes of this subsection which in no event shall exceed ten percent (10%) of the annual funding amounts for the small employer stop loss fund and the qualifying individual stop loss fund.

56-58-105. The commissioner shall order a study of the Healthy Tennessee program established pursuant to this chapter including an examination of employer participation, an income profile of covered employees and qualifying individuals, claims experience, and the impact of the program on the uninsured population. The study shall be completed and a report submitted by January 1, 2008, and annually thereafter, to the governor, the commission, the speaker of the senate and the speaker of the house of representatives.

56-58-106

(a) There is hereby established a general fund reserve to be allocated by the general appropriations act which shall be known as the "small employer stop loss fund." Moneys from the fund may be expended to fund activities authorized by this chapter. Any revenues deposited in this reserve shall remain in the reserve until expended for purposes consistent with this chapter, and shall not revert to the general fund on any June 30. Any excess revenues on interest earned by such revenues shall not revert on any June 30, but shall remain available for appropriation in subsequent fiscal years. Any appropriation from such reserve shall not revert to the general fund on any June 30, but shall remain available for expenditure in subsequent fiscal years.

(b) There is hereby established a general fund reserve to be allocated by the general appropriations act which shall be known as the "qualifying individual stop loss fund." Moneys from the fund may be expended to fund activities authorized by this chapter. Any revenues deposited in this reserve shall remain in the reserve until expended for purposes consistent with this chapter, and shall not revert to the general fund on any June 30. Any excess revenues on interest earned by such revenues shall not revert on any June 30, but shall remain available for appropriation in subsequent

fiscal years. Any appropriation from such reserve shall not revert to the general fund on any June 30, but shall remain available for expenditure in subsequent fiscal years.

56-58-107. The commissioner of commerce and insurance is authorized to promulgate rules and regulations to effectuate the purposes of this chapter. All such rules and regulations shall be promulgated in accordance with the provisions of Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 2. The provisions of this act shall not be construed to be an appropriation of funds, and no funds shall be obligated or expended pursuant to this act unless such funds are specifically appropriated by the general appropriations act.

SECTION 3. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 4. For purposes of rulemaking this act takes effect on becoming a law and for all other purposes this act shall take effect July 1, 2006, the public welfare requiring it.